



Notice of Independent Review Decision-WCN

April 20, 2010 (2nd amendment April 22, 2010)

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 4-20-10 (2ND AMENDMENT 4-22-10)

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical epidural steroid injection #1 with anesthesia and fluoroscopy.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

American Board of Anesthesiology and Pain Medicine

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☐ Upheld (Agree)
- ☒ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Employer's First Report of Injury.
- Accident report and investigation
- 1-22-10 MD., hand written notes.
- MD., office visits on 1-27-10, 2-17-10 and 3-15-10.
- MRI of the cervical spine dated 2-11-10.
- Physical therapy notes on 1-28-10, 2-1-10, 2-3-10, 2-5-10, 2-8-10, 2-10-10, 2-12-10, 2-15-10, 2-19-10, 2-22-10, 2-26-10, 3-1-10, 3-5-10.
- On 3-12-10, the claimant was evaluated by DO/ MD., office visit.
- 3-19-10 MD., performed a Utilization Review.
- Letter of reconsideration dated 3-24-10 provided by Dr..
- 4-1-10, MD., Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

On 1-27-10, examined the claimant who complained of neck and back pain and headaches as well. The claimant was not complaining of any numbness or tingling, just pain in the neck and back. On exam, the claimant has mild trapezius spasms bilaterally. He has normal range of motion at the neck. The claimant had some pain with palpation of the lower lumbar spine, but no spasms noted. DTR are 1+ and equal both upper and lower extremities. The claimant has normal strength in the upper and lower extremities. Dr. Reynold reviewed the x-rays and noted there was a questionable narrowing at C3-C4 and C5-C6. X-rays of the lumbar spine were normal. The evaluator provided the claimant with a prescription for Vicodin and referral to physical

therapy. If he does not improve in a month, then an MRI of the cervical spine would be requested to rule out herniated disc. The claimant was taken off work.

MRI of the cervical spine dated 2-11-10 shows a small 1mm to 2mm disc bulges/disc protrusions at the C2-C3 and C3-C4 levels. The spinal canal remains essentially normal in caliber at these levels. There appears to be some possible mild neural foraminal encroachment on the left. The right neural foramen appears essentially normal in caliber. There is some loss of disc signal at C4-C5, C5-C6 and C6-C7. The spinal canal and neural foramina appear essentially normal in caliber at these three segments.

Follow up with Dr. on 2-17-10 notes the claimant complains of neck pain and headaches. His range of motion of the neck is within normal limits. Neurologic exam is intact in both upper extremities. The MRI reviewed a HNP. The claimant was continued with rehab.

On 3-12-10, the claimant was evaluated by DO/ MD., the evaluator reported the claimant is a male who had to physically restrain a xxx with resultant injury to his spine. He reports pain in his neck and back with his back getting better however his neck remains painful. He describes his pain is achy and located in the lower to mid cervical spine region. He describes his usual level of pain as being very severe. Aggravating factors include standing and sitting with heat alleviating the pain. The pain is intermittent, present 3-4 days per week, with no specific pattern to the pain. The patient denies any bowel/bladder incontinence at this timer He has participated in 12 sessions of physical therapy which did help by his report the lower back but not the neck. An MRI of the cervical spine dated 2/11/10 does give the impression of a 2 mm disk bulge/disk protrusion at the C2/3 and C3/4 level. There appears to be some mild neural foraminal encroachment on the left. There is some loss of disc signal at the C4/5, C5/6, and C6/7 levels. He was evaluated by Dr. orthopaedic surgery, who has referred him for a cervical epidural steroid injection. Since he has not responded to conservative care in the form of physical therapy the next step in conservative care would be a diagnostic epidural steroid injection. No pain medications were prescribed at this office visits and he does receive medications from Dr.. The evaluator placed him on an anti-inflammatory medication to use over the next 10 days. Examination shows functional range of motion in the cervical spine region except with extension which is slightly limited. There's pain noted with extension of the cervical spine. There is tenderness to palpation of the cervical paraspinal musculature. Maximum point of tenderness seems to be around C6/7. There's also some tenderness in the trapezius musculature bilaterally. Neurological, exam is non focal. The claimant was given a prescription for Relafen 750 mg 1 p.p. b.i.d. with food # 20. The evaluator recommended diagnostic cervical epidural steroid injections.

A DWC-73 provided by Dr. on 3-15-10 notes the claimant was placed off work. The claimant was referred for cervical epidural steroid injection.

3-19-10 MD., performed a Utilization Review. The reviewer noted the claimant has findings on the left C4 with possible nerve root impingement, but no clear radicular symptoms. While an HNP at this level can present as neck pain, the description of neck pain in this claimant is not unilateral and not consistent with this level of herniation.

Letter of reconsideration dated 3-24-10 provided by Dr. notes the claimant has failed conservative therapy up to until now, including physical therapy and medications. He has radiographic evidence of cervical herniated disks with foraminal encroachment. His physical examination shows weakness of the left upper extremity with paresthesias of that upper extremity, signs of radiculopathy. He does meet the ODG criteria for cervical epidural steroid injection. The evaluator requested the case be reviewed by an anesthesiologist who performs invasive pain management 100% of the time, just like the provider.

On 4-1-10, MD., performed a Utilization Review. The reviewer noted that the claimant primarily complains of cervical pain. He notes that imaging reveals a 2 mm disc with only mild neural foraminal encroachment to the left. The claimant is also not shows to have multilevel degenerative disc disease. The neurological examination is within normal limits. There is no correlation of physical exam, complains by the claimant or the findings on MRI. The letter was nonspecific with regards to where the claimant had weakness, where the claimant had paresthesias, or why these were not mentioned in the physical exam and how this correlates with the claimant's imaging. As per ODG, cervical epidural steroid injection was denied.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

THE PROVIDER REPORTED THAT THE PATIENT DID HAVE WEAKNESS IN THE LEFT UPPER EXTREMITY AND PARESTHESIA. THERE ARE NO SPECIFICS ON THE DERMATOMAL DISTRIBUTION OF THE PARESTHESIA OR WHAT MUSCLES GROUPS WERE INDEED WEAK. THE PATIENT DID HAVE FINDINGS ON THE MRI WITH C4 INVOLVEMENT. I DO AGREE THAT A CERVICAL EPIDURAL STEROID INJECTION WOULD BENEFIT IN DECREASING THIS PATIENT'S LEVEL OF DISCOMFORT AS WELL AS PROVIDE ADDITIONAL INFORMATION ON DISCOGENIC INVOLVEMENT. THEREFORE, THE REQUESTED CERVICAL EPIDURAL STEROID INJECTION IS REASONABLE AND MEDICALLY INDICATED IN THIS SCENARIO.

ODG-TWC, last update 4-16-10 Occupational Disorders of the Neck and Upper Back – Cervical epidural steroid injection: Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. In a recent Cochrane review, there was one study that reported improvement in pain and function at four weeks and also one year in individuals with chronic neck pain with radiation. (Peloso-Cochrane, 2006) (Peloso, 2005) Other reviews have reported moderate short-term and long-term evidence of success in managing cervical radiculopathy with interlaminar

ESIs. (Stav, 1993) (Castagnera, 1994) Some have also reported moderate evidence of management of cervical nerve root pain using a transforaminal approach. (Bush, 1996) (Cyteval, 2004) A recent retrospective review of interlaminar cervical ESIs found that approximately two-thirds of patients with symptomatic cervical radiculopathy from disc herniation were able to avoid surgery for up to 1 year with treatment. Success rate was improved with earlier injection (< 100 days from diagnosis). (Lin, 2006) There have been recent case reports of cerebellar infarct and brainstem herniation as well as spinal cord infarction after cervical transforaminal injection. (Beckman, 2006) (Ludwig, 2005) Quadriplegia with a cervical ESI at C6-7 has also been noted (Bose, 2005) and the American Society of Anesthesiologists Closed Claims Project database revealed 9 deaths or cases of brain injury after cervical ESI (1970-1999). (Fitzgibbon, 2004) These reports were in contrast to a retrospective review of 1,036 injections that showed that there were no catastrophic complications with the procedure. (Ma, 2005) The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) There is evidence for short-term symptomatic improvement of radicular symptoms with epidural or selective root injections with corticosteroids, but these treatments did not appear to decrease the rate of open surgery. (Haldeman, 2008) (Benyamin, 2009) See the Low Back Chapter for more information and references.

Criteria for the use of Epidural steroid injections, therapeutic:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

- (1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.
- (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
- (3) Injections should be performed using fluoroscopy (live x-ray) for guidance
- (4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.
- (5) No more than two nerve root levels should be injected using transforaminal blocks.
- (6) No more than one interlaminar level should be injected at one session.
- (7) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.
- (8) Repeat injections should be based on continued objective documented pain and function response.
- (9) Current research does not support a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.

(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
(11) Cervical and lumbar epidural steroid injection should not be performed on the same day.

Criteria for the use of Epidural steroid injections, diagnostic:

To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:

- (1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;
- (2) To help to determine pain generators when there is evidence of multi-level nerve root compression;
- (3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g. dermatomal distribution) but imaging studies are inconclusive;
- (4) To help to identify the origin of pain in patients who have had previous spinal surgery.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☐ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)